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7
8 **BEFORE THE**
BOARD OF PHARMACY
9 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

10 In the Matter of the Accusation Against:

Case No. 5576

11 **MATS PHARMACY INC. DBA MATS**
12 **PHARMACY AND MEDICAL SUPPLIES,**
13 **BANJI ALADE ADERETI AND FUMNI**
MOJISOLA ADERETI, OWNERS

A C C U S A T I O N

14 3625 Martin Luther King Jr. Blvd., Ste. 1
Lynwood, CA 90262-3509
15 BANJI ALADE ADERETI, Pharmacist-in-
Charge

16 **Original Permit No. PHY 49180**

17 **BANJI ALADE ADERETI**
18 PO Box 1136
Placentia, CA 92670

19 **Original Pharmacist License No. RPH 45057**

20 Respondents.

21
22 Complainant alleges:

23 **PARTIES**

24 1. Virginia Herold ("Complainant") brings this Accusation solely in her official capacity
25 as the Executive Officer of the Board of Pharmacy, Department of Consumer Affairs.

26 2. On or about October 17, 2008, the Board of Pharmacy issued Original Permit Number
27 PHY 49180 to Mats Pharmacy Inc. doing business as Mats Pharmacy and Medical Supplies with
28 Banji Alade Adereti as the Pharmacist-in-Charge, President and the owner of fifty percent of the

1 outstanding shares and Fummi Mojisola Adereti as the Secretary and the owner of fifty percent of
2 the outstanding shares ("Respondent Pharmacy"). The Original Permit was in full force and effect
3 at all times relevant to the charges brought herein and will expire on October 1, 2016, unless
4 renewed.

5 3. On or about March 5, 1992, the Board of Pharmacy issued Original Pharmacist
6 License Number RPH 45057 to Banji Alade Adereti ("Respondent Adereti"). The Original
7 Pharmacist License was in full force and effect at all times relevant to the charges brought herein
8 and will expire on May 31, 2017, unless renewed.

9 JURISDICTION

10 4. This Accusation is brought before the Board of Pharmacy, Department of Consumer
11 Affairs ("Board"), under the authority of the following laws. All section references are to the
12 Business and Professions Code unless otherwise indicated.

13 5. Section 4300 provides, in pertinent part, that every license issued by the Board is
14 subject to discipline, including suspension or revocation.

15 6. Section 4300.1 states:

16 "The expiration, cancellation, forfeiture, or suspension of a board-issued license by operation
17 of law or by order or decision of the board or a court of law, the placement of a license on a
18 retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of
19 jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding
20 against, the licensee or to render a decision suspending or revoking the license."

21 STATUTORY PROVISIONS

22 7. Section 4022 states

23 "Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in
24 humans or animals, and includes the following:

25 "(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without
26 prescription," "Rx only," or words of similar import.

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1 "(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by
2 or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in
3 with the designation of the practitioner licensed to use or order use of the device.

4 "(c) Any other drug or device that by federal or state law can be lawfully dispensed only on
5 prescription or furnished pursuant to Section 4006."

6 8. Section 4036.5 states: "Pharmacist-in-charge" means a pharmacist proposed by a
7 pharmacy and approved by the board as the supervisor or manager responsible for ensuring the
8 pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of
9 pharmacy."

10 9. Section 4301 states:

11 "The board shall take action against any holder of a license who is guilty of unprofessional
12 conduct or whose license has been procured by fraud or misrepresentation or issued by mistake.
13 Unprofessional conduct shall include, but is not limited to, any of the following:

14

15 "(d) The clearly excessive furnishing of controlled substances in violation of subdivision (a)
16 of Section 11153 of the Health and Safety Code.

17

18 "(j) The violation of any of the statutes of this state, or any other state, or of the United
19 States regulating controlled substances and dangerous drugs.

20

21 "(o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the
22 violation of or conspiring to violate any provision or term of this chapter or of the applicable
23 federal and state laws and regulations governing pharmacy, including regulations established by the
24 board or by any other state or federal regulatory agency."

25 10. Section 4307 states, in pertinent part:

26 "(a) Any person who has been denied a license or whose license has been revoked or is
27 under suspension, or who has failed to renew his or her license while it was under suspension, or
28 who has been a manager, administrator, owner, member, officer, director, associate, or partner of

1 any partnership, corporation, firm, or association whose application for a license has been denied
2 or revoked, is under suspension or has been placed on probation, and while acting as the manager,
3 administrator, owner, member, officer, director, associate, or partner had knowledge of or
4 knowingly participated in any conduct for which the license was denied, revoked, suspended, or
5 placed on probation, shall be prohibited from serving as a manager, administrator, owner, member,
6 officer, director, associate, or partner of a licensee as follows:

7 “(1) Where a probationary license is issued or where an existing license is placed on
8 probation, this prohibition shall remain in effect for a period not to exceed five years.

9 “(2) Where the license is denied or revoked, the prohibition shall continue until the license is
10 issued or reinstated.”

11 11. Health and Safety Code Section 11153 states, in pertinent part:

12 “(a) A prescription for a controlled substance shall only be issued for a legitimate medical
13 purpose by an individual practitioner acting in the usual course of his or her professional practice.
14 The responsibility for the proper prescribing and dispensing of controlled substances is upon the
15 prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the
16 prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an
17 order purporting to be a prescription which is issued not in the usual course of professional
18 treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of
19 controlled substances, which is issued not in the course of professional treatment or as part of an
20 authorized narcotic treatment program, for the purpose of providing the user with controlled
21 substances, sufficient to keep him or her comfortable by maintaining customary use.”

22 **REGULATORY PROVISION**

23 12. California Code of Regulations, title 16, section 1761, states:

24 “(a) No pharmacist shall compound or dispense any prescription which contains any
25 significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any
26 such prescription, the pharmacist shall contact the prescriber to obtain the information needed to
27 validate the prescription.

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1 “(b) Even after conferring with the prescriber, a pharmacist shall not compound or dispense
2 a controlled substance prescription where the pharmacist knows or has objective reason to know
3 that said prescription was not issued for a legitimate medical purpose.”

4 **COST RECOVERY**

5 13. Section 125.3 states, in pertinent part, that the Board may request the administrative
6 law judge to direct a licentiate found to have committed a violation or violations of the licensing
7 act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the
8 case.

9 **CONTROLLED SUBSTANCES AND DANGEROUS DRUGS**

10 14. Alprazolam, brand name Xanax, is a Schedule IV controlled substance pursuant to
11 Health and Safety Code section 11057, subdivision (d)(1), and a dangerous drug pursuant to
12 Business and Professions Code section 4022.

13 15. Carisoprodol, brand name Soma, is a Schedule IV controlled substance pursuant to
14 Code of Federal Regulations, title 21, section 1308.14, subdivision (c)(6), and a dangerous drug
15 pursuant to Business and Professions Code section 4022, as of January 11, 2012.

16 16. Diazepam, brand name Valium, is a Schedule IV controlled substance pursuant to
17 Health and Safety Code section 11057, subdivision (d)(9), and a dangerous drug pursuant to
18 Business and Professions Code section 4022.

19 17. Norco, a combination product containing the controlled substance hydrocodone and
20 non-narcotic acetaminophen, is a Schedule III controlled substance pursuant to Health and Safety
21 Code section 11056, subdivision (e)(4), and a dangerous drug pursuant to Business and
22 Professions Code section 4022.

23 18. Promethazine with codeine syrup is a Schedule V controlled substance pursuant to
24 Health and Safety Code section 11058, subdivision (c)(1), and a dangerous drug pursuant to
25 Business and Professions Code section 4022.

26 19. Vicoden, a combination product containing the controlled substance hydrocodone and
27 non-narcotic acetaminophen, is a Schedule III controlled substance pursuant to Health and Safety
28

1 Code section 11056, subdivision (e)(4), and a dangerous drug pursuant to Business and
2 Professions Code section 4022.

3 FACTUAL BACKGROUND

4 20. On or about May 29, 2014, the Board initiated an investigation into Respondent
5 Pharmacy and Respondent Adereti (collectively, "Respondents") following receipt of
6 correspondence from Cardinal Health, a pharmaceutical distribution company, stating that the
7 company had suspended Respondent Pharmacy from ordering controlled substances because the
8 company determined that continued sales would create an unreasonable risk of potential diversion.

9 21. A Board Inspector reviewed CURES¹ data for all controlled substances that were
10 dispensed at Respondent Pharmacy, as reported by Respondent Pharmacy, between October 19,
11 2011, and October 30, 2014. The Board Inspector reviewed hard copies of prescriptions filled at
12 Respondent Pharmacy and Respondent Pharmacy's electronic computer records of dispensed
13 prescriptions, amongst other documents. The Board Inspector also interviewed Pharmacist-in-
14 Charge Respondent Adereti.

15 22. The Board Inspector's review identified factors of irregularity or red flags consistent
16 with illegitimate doctor prescribing and indiscriminate pharmacy dispensing. These red flags
17 included initial prescriptions written for strong dosages of opiates (in contrast to an initial
18 prescription at a lower dose, which is slowly raised to a higher dose); some patient profiles showed
19 the patient using prescription insurance for non-controlled substances yet paying with cash for
20 controlled substances (a review of Patient Activity Reports identified doctor shopping patterns for
21 these patients); and, Respondents also filled prescriptions in which groups of the same or similar
22 prescriptions were processed together, a factor of irregularity because it is unusual to have several
23 patients with the same diagnoses, all requiring the same drug therapy, to arrive in the pharmacy at

24 ¹ Controlled Substance Utilization Review and Evaluation System, or CURES, is a
25 database that contains over 100 million entries of controlled substance drugs that were dispensed
26 in California. CURES is part of program developed by the California Department of Justice and
27 Bureau of Narcotic Enforcement, which allows access to the Prescription Drug Monitoring
28 Program (PDMP) system. The PDMP allows pre-registered users including licensed healthcare
prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense
controlled substances, law enforcement and regulatory boards to access patient controlled
substance history information. (<http://oag.ca.gov/cures-pdmp>)

1 once. These red flags either gave, or should have given, Respondent Pharmacy and Respondent
2 Adereti sufficient information to identify potential problems with the prescriptions, and put them
3 on notice to conduct further inquiries into the legitimacy of the prescriptions.

4 **FIRST CAUSE FOR DISCIPLINE**

5 **(Filling Erroneous Prescriptions and Failure to Assume Corresponding Responsibility in** 6 **Legitimacy of Prescriptions)**

7 23. Respondents are subject to disciplinary action under section 4301, subdivisions (d), (j),
8 and (o), in conjunction with Health and Safety Code section 11153, subdivision (a), and California
9 Code of Regulations, title 16, section 1761, in that Respondents failed to comply with their
10 corresponding responsibility to only fill medically legitimate prescriptions, by failing to review
11 patients' drug history and by dispensing erroneous/uncertain prescriptions. The circumstances
12 include the presence of multiple red flags for irregular prescriptions coming from both the statistics
13 of a prescribing doctor as well as and from patients who sought early refills.

14 **A. Excessive Cash Payments**

15 24. Respondent Pharmacy dispensed 100,312 medications between October 29, 2011, and
16 October 30, 2014. Of these, 60,267, or 60.08%, were for non-controlled substances and 40,045,
17 or 39.92%, were for controlled substances. While 91% of the non-controlled substances were
18 billed to an insurance plan, only 45% of controlled substances were billed to insurance. The much
19 higher rate at which patients paid cash for controlled substances is a red flag because patients want
20 to receive financial assistance from insurance, but insurance companies will deny payment if a
21 patient is attempting to purchase an excessive amount of medication, or has previously purchased
22 the same medication at another pharmacy within a short period of time.

23 **B. Irregular Prescriptions**

24 25. Respondent Pharmacy dispensed 13,592 prescriptions written by Dr. E.R. between
25 October 29, 2011, and October 30, 2014. 80.29% of those prescriptions were for controlled
26 substances while 19.71% were for non-controlled substances. Furthermore, over 75% (or 10,275)
27 of Dr. E.R.'s prescriptions filled at Respondent Pharmacy were for Carisoprodol 350 mg,
28 alprazolam 2 mg, or hydrocodone combinations. None of the hydrocodone combinations

1 contained the lower strength, 5 mg, of hydrocodone and all of the alprazolam prescriptions were
2 for 2 mg. Of the controlled substance prescriptions written by Dr. E.R., 93.9% showed cash as
3 the payment, thus those patients received no financial assistance from insurance.

4 26. Many of the prescriptions written by Dr. E.R. and filled at Respondent Pharmacy
5 showed instances in which groups of the same or similar prescriptions were processed together.
6 This is a red flag because it is unusual to have several patients with the same diagnoses, requiring
7 the same drug therapy, arriving at the pharmacy at the same time. Some examples are as follows:

8 a. On February 1, 2013, per pharmacy records, between 10:52 a.m. and 11:30 a.m.,
9 Respondent Pharmacy entered twelve new prescriptions, for seven patients, that were written by
10 Dr. E.R. Pharmacy dispensing software assigns prescription numbers consecutively as
11 prescriptions are processed. Thus, between the relevant time period, every new prescription
12 entered by the pharmacy was written by Dr. E.R.² All twelve of the prescriptions were either for
13 Carisoprodol 350 mg or Hydrocodone/APAP 7.5/750. For the patients that had two prescriptions,
14 they had a prescription for each of the referenced controlled substances. It is a red flag for a
15 pharmacy to create twelve new sequential prescriptions for seven different patient from the same
16 doctor, and to have all of those prescriptions be for the same two controlled substances, within
17 such a short period of time.

18 b. On July 5, 2012, per pharmacy records, between 6:12 a.m. and 6:41 a.m., Respondent
19 Pharmacy entered thirteen prescriptions, for thirteen different patients, written by Dr. E.R. Ten of
20 the prescriptions were newly entered by Respondent Pharmacy with sequential prescription
21 numbers. Thus, between the relevant time period, every new prescription entered by the pharmacy
22 was written by Dr. E.R. All thirteen of the prescriptions were either for Carisoprodol 350 mg or
23 Hydrocodone/APAP 7.5/750. Additionally, two of the patients who had their prescriptions
24 entered (as refills) within one minute of each other had sequential prescription numbers for the
25 same prescription, Hydrocodone/APAP, indicating that they also had their original prescriptions

26
27 ² As pharmacy dispensing software only creates a prescription number for a new
28 prescription, Respondent Pharmacy may have entered or filled refills for old prescriptions during
this time period.

1 first entered by Respondents sequentially. It is a red flag for a pharmacy to enter thirteen
2 prescriptions from the same doctor for the same two controlled substances and for a pharmacy to
3 sequentially enter ten new prescriptions for the same two controlled substances from the same
4 doctor all within such a short time period.

5 c. On September 12, 2012, per pharmacy records, between 10:55 a.m. and 11:02 a.m.,
6 Respondent Pharmacy entered seven prescriptions, for seven different patients, written by Dr. E.R.
7 Six of the prescriptions were newly entered by Respondent Pharmacy with sequential new
8 prescription numbers. Thus, between the relevant time period, every new prescription entered by
9 the pharmacy was written by Dr. E.R. All seven of the prescriptions were for Carisoprodol 350
10 mg. It is a red flag for a pharmacy to enter seven prescriptions from the same doctor for the same
11 controlled substance and for a pharmacy to sequentially enter six new prescriptions for the same
12 controlled substances from the same doctor all within such a short time period.

13 d. On July 6, 2012, per pharmacy records, between 6:45 a.m. and 6:52 a.m., Respondent
14 Pharmacy entered ten prescriptions, for nine different patients, written by Dr. E.R. Seven of the
15 prescriptions were newly entered by Respondent Pharmacy with sequential prescription numbers.
16 Thus, between the relevant time period, every new prescription entered by the pharmacy was
17 written by Dr. E.R. Nine of the prescriptions were for Carisoprodol 350 mg and the other
18 prescription was for Hydrocodone/APAP 7.5/750. It is a red flag for a pharmacy to enter ten
19 prescriptions from the same doctor for the same two controlled substances and for a pharmacy to
20 sequentially enter seven new prescriptions for the same controlled substances from the same
21 doctor all within such a short time period.

22 e. On October 31, 2011, per pharmacy records, at 8:45 a.m., Respondent Pharmacy
23 entered four prescriptions, for four different patients, written by Dr. E.R. All four prescriptions
24 were for Alprazolam 2 mg. It is a red flag for a pharmacy to enter four prescriptions from the same
25 doctor for the same controlled substance, for four different patients within one minute of each
26 other.

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1 f. On October 9, 2012, per pharmacy records, between 12:26 p.m. and 12:28 p.m.,
2 Respondent Pharmacy entered four prescriptions, for four different patients, written by Dr. E.R.
3 All four of the prescriptions were newly entered by Respondent Pharmacy with sequential new
4 prescription numbers. All four of the prescriptions were for Hydrocodone/APAP 10/325. It is a
5 red flag for a pharmacy to create four new prescriptions from the same doctor, for the same
6 controlled substance, for four different patients, within such a short time period.

7 g. On July 2, 2012, per pharmacy records, between 6:11 a.m. and 6:19 a.m., Respondent
8 Pharmacy entered ten prescriptions, for five different patients, written by Dr. E.R. All ten of the
9 prescriptions were newly entered by Respondent Pharmacy with sequential new prescription
10 numbers. Thus, between the relevant time period, every new prescription entered by the pharmacy
11 was written by Dr. E.R. Each of the five patients had one prescription for Carisoprodol 350 and
12 one prescription for Hydrocodone/APAP 7.5/750. It is a red flag for a pharmacy to enter ten
13 prescriptions from the same doctor for five patients that all have the same two prescriptions within
14 such a short time period.

15 h. On October 17, 2012, per pharmacy records, between 11:52 a.m. and 12:12 p.m.,
16 Respondent Pharmacy entered eight prescriptions, for four different patients, written by Dr. E.R.
17 All eight of the prescriptions were newly entered by Respondent Pharmacy with sequential new
18 prescription numbers. Thus, between the relevant time period, every new prescription entered by
19 the pharmacy was written by Dr. E.R. Each of the four patients had one prescription for
20 Alprazolam 2 mg and one prescription for Hydrocodone/APAP 10/325. It is a red flag for a
21 pharmacy to enter eight prescriptions from the same doctor, for four patients that all have the same
22 two prescriptions, within such a short time period.

23 27. Many of the prescriptions written by Dr. E.R. showed instances in which patients
24 living at the same address received identical or very similar drug therapy. This is a factor of
25 irregularity because it is unusual for multiple patients in the same household to have the same
26 diagnoses requiring the same drug therapy. Some examples are as follows:

27 a. Six patients living at 10011 San Miguel each received several prescriptions for
28 alprazolam 2 mg and Hydrocodone/APAP 10/325. Five of the six patients also had nearly

1 identical names, and listed the address only slightly differently, such as San Miguel Avenue as
2 opposed to San Miguel Lane.

3 b. Three patients living at 1036 W. 98th Street each received several prescriptions for
4 Carisoprodol 350 mg and Hydrocodone/APAP 7.5/325.

5 c. Two patients living at 13131 S. Largo Avenue each received several prescriptions for
6 alprazolam 2 mg and Hydrocodone/APAP 10/325.

7 d. Two patients living at 14415 Lemoli Avenue received several prescriptions for
8 alprazolam 2 mg and Hydrocodone/APAP 10/325.

9 e. Two patients living at 1702 W. Arbor and 1702 W. Arbutus Str. Each received several
10 prescriptions for Carisoprodol 350 mg.

11 f. Seven patients, many of which with very similar names, living at 211 W. Cypress
12 Street each received many prescriptions for alprazolam 2 mg and Hydrocodone/APAP 10/325.

13 g. Two patients living at 724 W. Tichenor Street received several prescriptions for
14 Carisoprodol 350 mg and Hydrocodone/APAP 7.5/750.

15 h. Two patients living at 817 Flights Avenue received several prescriptions for
16 alprazolam 2 mg and Hydrocodone/APAP 10/325.

17 i. Three patients living at 4126 W. Century Boulevard received prescriptions for
18 Carisoprodol 350 mg in addition to Hydrocodone/APAP 7.5/750 and/or Acetaminophen/Codeine
19 300/60.

20 **C. Prescriptions for Promethazine with Codeine Syrup**

21 28. Respondent Pharmacy dispensed 8,579 prescriptions, totaling 8.54% of all
22 prescriptions filled, for promethazine with codeine syrup between October 29, 2011, and October
23 30, 2014. Given the variety of medical conditions treated by generally practitioners and the vast
24 amount of different treatment options available, it was a factor of irregularity that over 8% of the
25 prescriptions filled during this time period were for one medication. Additionally, Promethazine
26 with codeine syrup should be used for the temporary relief of coughs and upper respiratory
27 symptoms. The maximum suggested volume of medication per day of use is 30 milliliters, the
28 dosage should not be increased if the cough fails to respond, and a cough that is unresponsive after

1 five (5) days should be re-evaluated. Here, many patients received several consecutive months of
2 therapy with Promethazine with codeine syrup, a red flag since the medication is indicated for
3 short term treatment.

4 a. Patient J.B.: Patient J.B. received 240 mL once or twice each month for 15
5 consecutive months in combination with other controlled substances.

6 b. Patient W.B.: Patient W.B. received 240 mL once monthly for twelve consecutive
7 months and again for seven consecutive months in combination with other controlled substances.

8 c. Patient M.C.: Patient M.C. received 240 mL once or twice each month for 22
9 consecutive months in combination with other controlled substances.

10 d. Patient D.C.: Patient D.C. received 240 mL once monthly for two periods of nine
11 consecutive months and then eight consecutive months in combination with other controlled
12 substances.

13 e. Patient J.C.: Patient J.C. received 240 mL once or twice a month for twelve
14 consecutive months and again for five consecutive months in combination with other controlled
15 substances.

16 f. Patient A.E.: Patient A.E. received 240 mL twenty-eight times over thirty-two
17 months between October 2011 and May 2014 in combination with other controlled substances.

18 g. Patient M.E.: Patient M.E. received 240 mL once monthly for seventeen consecutive
19 months in combination with other controlled substances.

20 h. Patient G.M.: Patient G.M. received 240 mL once monthly for twenty-one months in
21 combination with other controlled substances.

22 **D. Initiation of Therapy with High Doses**

23 29. Standard practice for prescribers is to initiate therapy with a low dose of medication
24 and increase the dose if necessary. Dispensing data for Respondents showed many instances
25 where the patients' initial prescriptions were for the highest available dose.

26 a. Alprazolam is available in 0.25 mg tablets, 0.5 mg tablets, 1 mg tablets, and 2 mg
27 tablets. Between October 29, 2011, and October 30, 2014, Respondent Pharmacy dispensed 4479
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1 prescriptions for alprazolam 2 mg tablets to a total of 953 patients. Respondent Pharmacy only
2 dispensed 106 prescriptions to 38 patients for all other strengths of alprazolam combined.

3 b. Diazepam is available in 2 mg, 5 mg, and 10 mg tablets. Between October 29, 2011,
4 and October 30, 2014, Respondent Pharmacy dispensed 1,894 prescriptions for diazepam 10 mg
5 tablets to a total of 359 patients. Respondent Pharmacy dispensed only 48 prescriptions to 10
6 patients for all other strengths of diazepam combined.

7 **E. Controlled Substance Prescriptions Filled Too Early**

8 30. Respondents also failed to assume corresponding responsibility by filling a large
9 number of controlled substance prescriptions early. Early refills are defined as controlled
10 substance prescriptions that were filled more than five days before a previous prescription was
11 scheduled to expire. A Board of Pharmacy Inspector reviewed Prescription Drug Monitoring
12 Program Patient Activity Reports ("PAR" or "PARs") for 29 patients whose profiles showed a
13 pattern of paying cash for controlled substances and billing insurance for non-controlled substances
14 from Respondent Pharmacy between October 29, 2011, and October 30, 2014. 21 of the 29 PARs
15 showed multiple instances of early refills, where patients visited multiple pharmacies and received a
16 refill from a pharmacy before their prior filling of a prescription at a different pharmacy was
17 expected to be finished. Had Respondents recognized the multiple red flags above and reviewed
18 PARs, a freely available resource to all pharmacists, Respondents would have identified multiple
19 instances of early refilling and doctor shopping, as follows:

20 a. Patient J.B.: The PAR showed that J.B. used approximately 15 different pharmacies,
21 including Respondent Pharmacy, between December 2011 and July 2013. During this time period
22 J.B. obtained 25 early refills that consisted of either Hydrocodone/APAP 7.5/750 mg or
23 Carisoprodol 350 mg from Respondent Pharmacy.

24 b. Patient V.B.: The PAR showed that V.B. used 7 different pharmacies, including
25 Respondent Pharmacy, between May 2012 and October 2013. During this time period V.B.
26 obtained 26 early refills that consisted of either Carisoprodol 350 mg or Acetaminophen/Codeine
27 300/60 mg from Respondent Pharmacy.

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1 c. Patient J.B.2: The PAR showed that J.B.2 obtained an early refill of
2 Hydrocodone/APAP 7.5/325 mg from Respondent Pharmacy only three days after J.B.2 had
3 received a fifteen day supply in August 2014 from another pharmacy.

4 d. Patient C.B.: The PAR showed that C.B. used 15 different pharmacies, including
5 Respondent Pharmacy, between November 2011 and August 2013. During this time period C.B.
6 obtained 20 early refills that consisted of either Carisoprodol 350 mg or Hydrocodone/APAP
7 7.5/750 mg from Respondent Pharmacy.

8 e. Patient M.C.: The PAR showed that M.C. used 6 different pharmacies, including
9 Respondent Pharmacy, between October 2012 and December 2013. During this time period M.C.
10 obtained 12 early refills that consisted of either Acetaminophen/Codeine 300/30 mg or Diazepam
11 10 mg from Respondent Pharmacy.

12 f. Patient S.F.: The PAR showed that S.F. used 3 different pharmacies, including
13 Respondent Pharmacy, between April 2012 and May 2013. During this time period S.F. obtained
14 4 early refills of Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy.

15 g. Patient J.H.: The PAR showed that J.H. used 3 different pharmacies, including
16 Respondent Pharmacy, in March of 2012. During this time period J.H. obtained 2 early refills of
17 Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy.

18 h. Patient S.H.: The PAR showed that S.H. used 4 different pharmacies, including
19 Respondent Pharmacy, between December 2012 and December 2013. During this time period
20 S.H. obtained 10 early refills of either Carisoprodol 350 mg or Hydrocodone/APAP 7.5/750 mg
21 from Respondent Pharmacy.

22 i. Patient B.J.: The PAR showed that B.J. used 10 different pharmacies, including
23 Respondent Pharmacy, between April 2012 and April 2014. During this time period B.J. obtained
24 19 early refills that consisted of either Carisoprodol 350 mg or Hydrocodone/APAP 7.5/750 mg
25 from Respondent Pharmacy.

26 j. Patient A.K.: The PAR showed that A.K. used 5 different pharmacies, including
27 Respondent Pharmacy, between November 2011 and January 2014. During this time period A.K.
28

1 obtained 26 early refills that consisted of either Carisoprodol 350 mg or Hydrocodone/APAP
2 7.5/750 mg from Respondent Pharmacy.

3 k. Patient E.K.: The PAR showed that E.K. used 9 different pharmacies, including
4 Respondent Pharmacy, between October 2011 and October 2013. During this time period E.K.
5 obtained 32 early refills that consisted of Carisoprodol 350 mg, Hydrocodone/APAP 7.5/750 mg,
6 and Alprazolam 2 mg from Respondent Pharmacy.

7 l. Patient R.M.: The PAR showed that R.M. used 5 different pharmacies, including
8 Respondent Pharmacy, between November 2011 and May 2013. During this time period R.M.
9 obtained 15 early refills that consisted of either Carisoprodol 350 mg or Hydrocodone/APAP
10 7.5/750 mg from Respondent Pharmacy.

11 m. Patient G.R.: The PAR showed that G.R. used 10 different pharmacies, including
12 Respondent Pharmacy, between November 2011 and December 2013. During this time period
13 G.R. obtained 59 early refills that consisted of Alprazolam 2 mg, Hydrocodone/APAP 7.5/750 mg,
14 and Carisoprodol 350 mg from Respondent Pharmacy.

15 n. Patient S.S.: The PAR showed that S.S. used 12 different pharmacies, including
16 Respondent Pharmacy, between December 2011 and November 2013. During this time period
17 S.S. obtained 39 early refills that consisted of Alprazolam 2 mg, Hydrocodone/APAP 7.5/750 mg,
18 and Carisoprodol 350 mg from Respondent Pharmacy.

19 o. Patient S.S.2: The PAR showed that S.S.2 used 5 different pharmacies, including
20 Respondent Pharmacy, between November 2011 and August 2013. During this time period S.S.2
21 obtained 9 early refills that consisted of either Acetaminophen/Codeine 300/60 mg, or Diazepam
22 10 mg from Respondent Pharmacy.

23 p. Patient Y.S.: The PAR showed that Y.S. used 4 different pharmacies, including
24 Respondent Pharmacy, between January 2012 and July 2013. During this time period Y.S.
25 obtained 8 early refills of Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy.

26 q. Patient D.S.: The PAR showed that D.S. used 2 different pharmacies, including
27 Respondent Pharmacy, between May 2012 and July 2014. During this time period D.S. obtained
28

1 30 early refills that consisted of either Clonazepam 2 mg, or Hydrocodone/APAP 7.5/750 mg from
2 Respondent Pharmacy.

3 r. Patient Y.T.: The PAR showed that Y.T. obtained an early refill of
4 Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy. Y.T. received a fifty-three (53) day
5 supply of Hydrocodone / APAP in the previous eight (8) days.

6 s. Patient C.W.: The PAR showed that C.W. used 3 different pharmacies, including
7 Respondent Pharmacy, between November 2011 and August 2013. During this time period C.W.
8 obtained 21 early refills that consisted of either Carisoprodol 350 mg or Hydrocodone/APAP
9 7.5/750 mg from Respondent Pharmacy.

10 t. Patient M.W.: The PAR showed that M.W. used approximately 25 different
11 pharmacies, including Respondent Pharmacy, between January 2012 and September 2013. During
12 this time period M.W. obtained 45 early refills that consisted of Diazepam 10 mg,
13 Hydrocodone/APAP 7.5/750 mg, and Carisoprodol 350 mg from Respondent Pharmacy.

14 u. Patient E.W.: The PAR showed that E.W. obtained an early refill of Diazepam 10 mg
15 from Respondent Pharmacy only six days after E.W. had received a thirty day supply in June of
16 2014. The PAR also showed that E.W. obtained a second early refill of Diazepam 10 mg from
17 Respondent Pharmacy only eleven days after E.W. had received a thirty day supply in July of 2014

18 v. Patient F.W.: The PAR showed that F.W. used 8 different pharmacies, including
19 Respondent Pharmacy, between October 2011 and February 2014. During this time period F.W.
20 obtained 44 early refills that consisted of either Hydrocodone/APAP 7.5/750 mg, or Carisoprodol
21 350 mg from Respondent Pharmacy.

22 **SECOND CAUSE FOR DISCIPLINE**

23 **(Excessive Furnishing of Controlled Substances)**

24 31. Respondents are subject to disciplinary action under section 4301, subdivisions (d), (j),
25 and (o), in conjunction with Health and Safety Code section 11153, subdivision (a), in that
26 Respondents engaged in the clearly excessive furnishing of controlled substances, suggesting a
27 level of specificity from patients when choosing what pharmacy to use when filling specific
28 controlled substances. Respondent Pharmacy dispensed a significantly higher number of four

commonly abused controlled substances when compared to other pharmacies in close proximity as follows:

a. Respondent Pharmacy dispensed 265,885 tablets of Alprazolam 2 mg between October 29, 2011, and October 30, 2014, whereas a CVS Pharmacy 0.3 miles away dispensed 20,426 tablets of the controlled substance at that strength, IntraRx Drugs 0.2 miles away dispensed 2,885 tablets and Century Wood Pharmacy 0.2 miles away dispensed 760 tablets during this time period.

b. Respondent Pharmacy dispensed 506,440 tablets of Carisoprodol 350 mg between January 11, 2012, and October 30, 2014, whereas a CVS Pharmacy 0.3 miles away dispensed approximately 62,054 tablets of the controlled substance at that strength, IntraRx Drugs 0.2 miles away dispensed approximately 49,769 tablets and Century Wood Pharmacy 0.2 miles away dispensed approximately 11,458 tablets during this time period.

c. Respondent Pharmacy dispensed 351,583 tablets of Hydrocodone / APAP 10/325 mg between October 29, 2011, and October 30, 2014, whereas a CVS Pharmacy 0.3 miles away dispensed 106,466 tablets of the controlled substance at that strength, IntraRx Drugs 0.2 miles away dispensed 25,691 tablets and Century Wood Pharmacy 0.2 miles away dispensed 7,611 tablets during this time period.

d. Respondent Pharmacy dispensed 493,202 tablets of Hydrocodone / APAP 7.5/750 mg between October 29, 2011, and October 30, 2014, whereas a CVS Pharmacy 0.3 miles away dispensed 70,207 tablets of the controlled substance at that strength, IntraRx Drugs 0.2 miles away dispensed 93,923 tablets and Century Wood Pharmacy 0.2 miles away dispensed 27,331 tablets during this time period.

OTHER MATTERS

32. Pursuant to section 4307, if discipline is imposed on Original Permit Number PHY 49180 issued to Mats Pharmacy Inc., Mats Pharmacy Inc. shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Original Permit Number PHY 49180 is placed on probation or until Original Permit Number PHY 49180 is reinstated if the license is revoked.

33. Pursuant to section 4307, if discipline is imposed on Original Permit Number PHY 49180 issued to Mats Pharmacy Inc., while Banji Alade Adereti and/or Fumni Mojisola Adereti have been officers and owners and had knowledge of, or knowingly participated in, any conduct for which Mats Pharmacy Inc. was disciplined, Banji Alade Adereti and/or Fumni Mojisola Adereti shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Original Permit Number PHY 49180 is placed on probation or until Original Permit Number PHY 49180 is reinstated if the license is revoked.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Pharmacy issue a decision:

1. Revoking or suspending Original Permit Number PHY 49180, issued to Mats Pharmacy Inc. doing business as Mats Pharmacy and Medical Supplies with Banji Alade Adereti as the Pharmacist-in-Charge;

2. Revoking or suspending Original Pharmacist License Number RPH 45057 issued to Banji Alade Adereti;

3. Prohibiting Mats Pharmacy Inc. from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Original Permit Number PHY 49180 is placed on probation or until Original Permit Number PHY 49180 is reinstated if Original Permit Number PHY 49180 issued to Mats Pharmacy Inc. is revoked;

4. Prohibiting Banji Alade Adereti from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Original Permit Number PHY 49180 is placed on probation or until Original Permit Number PHY 49180 is reinstated if Original Permit Number PHY 49180 issued to Mats Pharmacy Inc. is revoked;

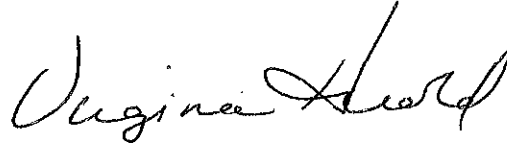
5. Prohibiting Fummi Mojisola Adereti from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Original Permit Number PHY 49180 is placed on probation or until Original Permit Number PHY 49180 is reinstated if Original Permit Number PHY 49180 issued to Mats Pharmacy Inc. is revoked;

1 6. Ordering Mats Pharmacy and Medical Supplies and Banji Alade Adereti to pay the
2 Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant
3 to Business and Professions Code section 125.3; and,

4 7. Taking such other and further action as deemed necessary and proper.
5
6

7
8 DATED: _____

4/8/16



VIRGINIA HEROLD
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
State of California
Complainant

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